SCRUTINY DEVELOPMENT SESSION

HEALTH AND WELLBEING SCRUTINY COMMISSION

WEDNESDAY 18 SEPTEMBER 2013 at 5.30pm

PRESENT

Councillors

Councillor Cooke
Councillor Chaplin (from 6.57pm onwards)
Councillor Desai
Councillor Sangster
Councillor Singh

Observers

Mr S Sharma

Officers
Rod Moore
Graham Carey

Facilitator
Brenda Cook

Apologies for Absence
Councillor Chaplin (attending Planning Committee)
Councillor Cleaver
Councillor Grant (attending Children and Young Peoples Scrutiny Commission)
Councillor Westley
Anita Patel

Introductions and Welcome

Councillor Cooke welcomed everyone to the meeting and introduced Brenda Cook who had been engaged through the Centre for Public Scrutiny (CfPS) as an Expert Health Scrutiny Advisor to carry out a 'Fit for Purpose' review. Brenda's role would be to advise and assist members in their discussions to plan the work programme.

The work programme was a flexible document which would be continually reviewed throughout the scrutiny year. This session had been arranged to discuss the Commission's workload and determine how best it could carry out its responsibilities.

Principles of Scrutiny

Members agreed with the four principles suggested by the CfPS, namely:-

- To provide a critical friend challenge to the executive policy makers and decision makers;
- To enable the voice and concerns of the public and communities to be heard;
- To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process;
- To drives improvements in services and finds efficiencies.

Members added two further local principles:-

- To prevent duplication of effort and resources;
- To seek assurances of quality from stakeholders and providers of services.

During discussion on potential barriers to scrutiny and to the issues that should be considered as part of a successful scrutiny process, the following points were raised:-

- New service areas to local government, e.g. Public Health, could be wary of questions being asked of services, priorities and processes.
- If scrutiny is carried out in a positive atmosphere, it can be beneficial to both the service area and the Council.
- Scrutiny should be focused at a strategic rather than local/parochial level.
- The Francis report emphasised the need for Scrutiny Commissions to listen to issues/concerns of patients, carers and communities however these were expressed. Scrutiny should also pick up on media reports etc and move them forward. Scrutiny Commissions should pull together and strengthen the public's 'voice' by asking questions of providers and services.
- The NHS was traditionally regarded as being an insular institution and cultural changes were needed to open the relationship with Scrutiny Commissions to engage in positive scrutiny of their services locally.
- Scrutiny should not be 'political' in nature but objective and factually based to provide evidence based influencing to improve services.
- Scrutiny should avoid merely asking questions and seeking knowledge of a subject area rather than trying to look for lessons from past and existing service provision etc with a view to focusing on making improvements.

- Members raised an issued where they had previously been consulted at the end of the process and had too little time in which to make a realistic contribution and public consultation had been based upon 2% sample. In future, Scrutiny could raise the concerns over the process with an overarching body such as NHS England, indicate to the health body that that a greater period of consultation should be allowed for the Scrutiny Commission to respond and that the Commission would expect to see more than a 2% consultation coverage with the public. The Commission could also devise a protocol for consultation and ask the health body for their comments upon it.
- A clear protocol needed to be developed to differentiate between the work and role of the Health and Wellbeing Board and that of the Commission, to both avoid duplication and have a clear understanding of both bodies' functions and roles.
- Some Council's include their key principles of scrutiny at the front of an agenda to identify and reinforce their role to the public.
- Although health scrutiny by local authorities has been in existence for over ten years, the health economy had undergone dramatic changes since April 2013 and both the health economy and scrutiny needs to evolve together to accommodate the requirement of scrutiny, particularly in relation to the post 'Francis Report' era.
- Scrutiny needed to recognise and reflect upon the different perceptions that each party involved in scrutiny can have of each other and this should be managed and accommodated as part of the scrutiny process.

Discussion took place on where scrutiny should place itself to maximise its effectiveness within the resources available and to provide the maximum benefit to the provision of health care services to local residents. The following methods and thoughts for future consideration were noted:-

- It was vital to identify what issues were important locally and to identify gaps in service based on information provided by the stakeholders.
- The CfPS had various tried and tested 'modelling tools' to define and determine how scrutiny could quantify its impact. These included tools to carry out impact assessments and to measure the return on investment of scrutiny.
- A starting point could be to identify and address the major causes of death and illnesses in the City such as:-
    - Cancer
    - COPD/Smoking
    - Heart disease
    - Diabetes
    - Infant Mortality

- Infectious diseases such as TB, HIV, and health protection measures
- Integrated care

Rod Moore undertook to carry out the initial work on this process.

- It was also important to monitor how the population was changing and the impacts this could have upon service provision and to look at what changes were needed in the provision of existing services to address any changing needs. E.g. some local communities had high levels of diabetes in 20-30 year old age range but the NHS model is geared to the diagnosis of diabetes in the 40 plus years old age range. Is that model suitable for Leicester's needs? Should more be done to look at the management of people diagnosed with diabetes in the primary care sector?
- Private providers of health care services were now within the remit of local authority scrutiny if the services were funded through NHS funds.
- Part of scrutiny's strength was that it could ask for assurances from NHS funded health providers at all levels in the sector and, if the scrutiny is not satisfied with the assurances given or the performance of a service, it has a valid role in stating that view publically in order to raise the profile of the issue.

<u>Areas of work that the Commission could consider</u>

- <u>Public Health Budgets and structures</u> –some priorities may be driven by national policy and may not be a local priority. The Commission should have assurance that the focus of the local Public Health resources was on local public health priorities

- <u>Quality Accounts and Performance</u> – likely to be available for scrutiny in March/April each year. Some local authorities, e.g. Warwickshire, were now approaching Trusts to indicate that they wished to be involved in discussions at an early stage and were involved in dialogue all through the year as a 'critical friend' to target the approach to what is important locally.

- <u>Key Decisions Impacting Upon Health</u> – City Mayor's Forward Plan.

- <u>Responding to consultations and engaging in formal and informal NHS consultation processes.</u> Commissioners and providers have a duty to consult the local authority scrutiny function on substantial variations and changes to service provision, although 'substantial' is not defined in law. Scrutiny could be proactive by initiating dialogue with commissioners and providers to indicate the scope of issues and the circumstances in which it would expect to be consulted. This template for consultation could also incorporate advice for

when consultation should take place and to avoid consultation during religious festivals etc.

- From April 2013 the Council has to be consulted by the commissions and providers though the mechanism which the Council has adopted for its scrutiny of health matters. The Health and Wellbeing Board should be consulted separately. There is no automatic right for the Council to be consulted on how the NHS intends to undertake its consultation of the public, only its consultation of the Council.
- If the NHS determines that the issue is not considered to be 'substantial', then this should be supported by evidence of involvement of working with different communities/county groups etc to come to this view . The Council, however, would have a valid role in scrutinising how the NHS engaged with those communities and groups.

- Holding to Account Health Care Providers and Commissioners. How this is done is entirely at the Commission's discretion. It can also incorporate the other statutory monitoring processes such as the role of the CQC and the newly appointed Chief Inspector of Hospitals.

- Receiving Reports/Updates on changes in Health Service Provision and Strategies.

- Ensure Reduced Health Inequalities. This could involve considering issues such as, access to services, quality health services and patient care and protection.

Possible Topics of interest to future scrutiny work programme could include:-

- On-going post Francis Issues
- Winter Planning of Health Service Provision
- EMAS – Being the Best
- Transition of NHS Trusts to become Foundation Trusts
- Developments in local Healthwatch and Health and Wellbeing Board
- NHS commissioning landscape
- Better Care Together
- NHS Trusts – review/monitor performance data and complaints data
- Annual Reports - LOROS, UHL, ICAS. LPT and Healthwatch
- NHS 111 Service
- Hospital Discharges
- A+E – Elderly and Frail Unit
- Homelessness Strategy - Implementation
- Corporate Strategies – monitoring role e.g 'Closing the Gap'
- Sickle Cell Anemia Services

- BME Groups – targeting specific health services
- HIV/Aids Services
- Mental Health Services, including BME provision
- Public Health Team Structures
- Fit for Purpose Review – addressing actions and outcomes
- Drugs an d Alcohol – specific campaigns
- Dementia Care Strategy

Joint Working

a) the Chair of the Commission had already agreed in principle with the Chair of the Adult Social Care Scrutiny Commission to undertake joint scrutiny on cross cutting issues. The following issue were considered as suitable for joint scrutiny:-
   - Winter Planning.
   - A&E – Emergency Floor Scheme.
   - Elderly and Frail services.
   - Hospital Discharges processes.
   - Mental Health Services.

   It was agreed that the issue of Winter Planning should be considered at the next Commission meeting.

b) there were also merits and economies in undertaking joint scrutiny with the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to avoid duplication on major topics of interest where health trusts wished to consult all three Councils. By having one discussion at a Joint Scrutiny Committee instead of a trust visiting all three local authorities could be beneficial to all concerned.

c) regional methods of scrutiny should also be explored further.

d) the Commission could contact health care providers to indicate that it would welcome and value the opportunity to visit service providers. Members undertaking such visits could formally report back to the Commission on their visits.

The Chair thanked everyone for their participation in the discussions and felt that it had raised some very useful reference points for the future. A number of these issues would be taken further in future development sessions.

The meeting ended at 7.35pm.